SUMMARIES

Nursing in Modern Japan and its Significance: The Kyoto Training School for Nurses and the Kyoto Nursing School

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Nursing by Buddhist during Meiji Japan was stimulated by the visiting nursing program conducted by nurses connected with the Kyoto Training School for Nurses. Why were Buddhist priests attracted to the visiting nursing, what did they try to adopt and what kind of nursing activities did they try to organize? As the first step to answer these questions, in this paper I considered the specialty, the sociality, and the nursing spirit of the home nursing and district nursing provided by the Kyoto Training School for Nurses. Moreover, through using material concerning the Kyoto Nursing Association by the graduates from the Kyoto Training School for Nurses, I investigated the visiting nursing activities in modern Kyoto.

The nursing activities noted above played a role going beyond the usual framework of medical treatment. The Kyoto Training School for Nurses was founded to promote westernization and charity. Nursing care was provided for the sick and child-rearing mothers, both in the hospitals and in their own homes, by nurses with professional knowledge and skills and possessing professional ethics. Not only did they care for the sick directly in cooperation with physicians, but they also planned and practiced care including the lives of the patients and their families. At times, they also helped spread modern notions of hygiene and medical treatment among the people.

Nursing, while constituting a modern profession, was at the same time practiced the charity based on Christianity having the propagation of Christianity as its mission. Nursing supported by faith was practiced autonomously, and at times also offered the spiritual healing. Buddhist works assumed modernity by adopting this nursing method and became the embodiment of Buddhist compassion by

Buddhists. These practices were training for Buddhists. Modern nursing became a part of Buddhist practice.

On the other hand, the Kyoto Nurse Society run by the graduates from the Kyoto Training School for Nurses created a curriculum based on western modern medicine following the educational system of the Kyoto Training School for Nurses, set forth guidelines for professional ethics, and trained nurses. Visiting nursing was treated professionally. The Kyoai Nurse Society emphasized spiritual nursing in addition to professional training. It is assumed that both nurse societies practiced nursing activity autonomously in cooperation with physicians.

At the end of 19th century, the increase of the number of nurses in the social context led to its professional diversification. Even while the qualifications for the nursing profession remained unregulated, a variety of factors such as the expansion of hospital care, recurrence of epidemics, wars, the increase of practitioners, and medical progress, introduced the period of mass production of nurses. Nursing as profession began to assume a character that complemented the system directly and indirectly. In such a situation, the existence of nursing, originating in the Kyoto Training School for Nurses, which attracted people connected to Buddhism, provided the opportunity to consider the meaning and possibility of nursing for the sick, the meaning of healing and being healed, and the identity of nursing.

Bioethics and Religion: The Limit of Bioethics

KURATA, Nobuo

During 1960's and 70's, new medical technologies gave rise to new ethical problems. Treating philosophical and irreligious standpoints, bioethics tried to suggest some normative judgements concerning these problems. Bioethics is based on philosophical ethics, such as utilitarianism and Kantian ethics. Hence bioethics is rational, formal, abstract, and secular.

In pluralistic societies such as America, where moral/social values and religions coexist, bioethicists have to treat new ethical problems concerning new

medical technologies using universal principles. In order to maintain objectivity and remain neutral concerning religious values, bioethicists have argued that their science is secular. In bioethics, some religious virtues are presented as secular principles.

Some theories of bioethics are presented as counter-arguments against Christian opinions. Christian ethic has forbidden abortion, but bioethics has dared to attack such values. For such reason, bioethics has avoided appealing to religious or spiritual values. For example, in the case of terminal care, bioethicists have discussed in detail the refusal of treatment by the dying patients and euthanasia, but they have rarely considered the patients' spiritual difficulties. In such cases, bioethics is not so useful.

Patients, physicians and nurses need vocabularies to rationalize the absurdity of death. Religious or spiritual narratives can provide such vocabularies. My death or deaths of others can be supplied with meaning through such narratives. We can prepare for our death by situating our deaths in some story. We can accept the deaths of others with some narratives. But in Japan, Buddhism is polluted by commercialism, so I doubt if Buddhism can provide any meaningful narrative. Indeed when people in Japan use spiritual terminology to talk about death, most of them are not those of Buddhism.

What is Narrative?
Towards a Narrative Therapy

NAKAGAWA, Akira

In the field of clinical psychology in Japan, "narrative" is an important term since many clinical psychologists hope that the concept of narrative will help overcome the present confused situation of psychotherapy.

We medical doctors sometimes consider diagnosis too serious. However, psychological phenomenon is very subtle, so we cannot handle diagnosis easily. There are two ways to understand psychological phenomenon: the categorical way, and the dimensional way. The former is preferred in medical field, while the lat-

ter is preferred in psychological field. But the schools of narrative mention neither category nor dimension.

Narrative therapy proposes that people use certain stories about themselves like the lens on a camera. These stories have the effect of filtering a person's experience and thereby selecting what information gets focused in or focused out. In this paper, I present some cases that I experienced. Almost all the cases are related to terminal care. I think narrative therapy can play an important role in terminal care.

A Cultural Anatomy of the World of Terminal Care

MURAOKA, Kiyoshi

Modern medicine in Jappan was never interested in taking care of terminally ill patients in hospitals until the practice of the terminal care such as "hospice movement" began in 1980s. Instead most doctors and nurses performed futile CPR (cardiopulmonary resuscitation) for patients with cardiac arrests and patient suffering from the incurable cancer. However, today many health care professionals recognize the necessity of the terminal care. This paper aims to examine the way in which the world of terminal care is embodied in Japan, and consider the issues of this world from different viewpoints.

First, three cases are introduced for discussion: The first describes how a paternalistic doctor-patient relationship led a surgeon to take no terminal care of his patient whose cancer has recurred. The second describes how a doctor succeeded in forming a sense of "immortality" in the mind of a terminally ill patient by satisfying her last hope. And, the third case takes up a story of spiritual care in which the life of a young man suffering from cancer was saved by a priest who was his roommate in the surgical ward. "Immortality" here refers to the realization by the dying person that they somehow continue to exist through someone or something such as their sons and daughters, inventions and works, and belief in life after death.

The three case studies show that not only the staff in the palliative care unit,

but also health care professionals working in a general ward are able to bring about an ideal terminal care, only if both medical staff and patients can communicate very well and sympathize each other. Terminal care depends on the relations between them.

Secondly, two more cases are taken up: that of a 67 year-old man who was severely "mentally retarded", and a four day-old baby "disabled" due to a chromosome anomaly. Through these case studies, I compared the view of "S.O.L. (sanctity of life) ethic" and that of "Q.O.L. (quality of life) ethic". The former emphasizes that every life has equal and sacred value, while the latter focuses on the fact that the value of each life is different, and that it is ethical to consider that the lives valued lowest such as "brain-dead" or "persistent vegetative" patients need not necessarily be protected any more. They are controversial in the recent context of the terminal care.

The SOL ethic is a traditional view of "life and death" that Buddhism and other religions have historically upheld in their precepts and commandments. The position supporting the euthanasia and "death with dignity," which is a kind of passive euthanasia, is a sort of Q.O.L. ethics.

Thirdly, the difference between at-home care and the care in the hospital was compared. Although large-scale medical treatment cannot be conducted in at-home care, it has the advantage of ensuring individual privacy easily, having a freer hand, and living a more convenient life at home. A hospital, however, is not the place where the patient and family can really exchange farewell with each other. At-home care is expected to become the dominant alternative way of terminal care in Japan, because not only family members and relatives but also friends and volunteer are able to participate more easily in terminal care.

Finally, the question of what the original terminal care should be was discussed. It might cope with various types of deaths, which are not necessarily those of "well-conditioned" terminally ill patients with incurable cancer in the palliative care hospital. Terminal caretakers need not necessarily be so-called specialists of terminal care such as medical professionals in palliative care unit. Rather people closer to the dying, such as family members and friends who gather by the bedside of the dying person to send him/her off, are more desirable.